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days or 85% of the total days during the cost report period. The total days are based on the number of licensed beds of the nursing facility, multiplied by the number of days in the cost report period. The 85% minimum occupancy rule does not apply to providers who file projected cost reports for an interim rate.

The allowable historic per diem cost is adjusted by the historic and estimated inflation factors. These inflation factors will be explained in greater detail in another section. The inflated allowable historic per diem cost for each cost center is then compared to the cost center per diem limitation.

The allowable per diem rate is the lesser of the inflated allowable historic per diem cost in each cost center or the cost center per diem limitation. Each cost center has a separate limitation. If each cost center limitation is exceeded, the allowable per diem rate is the sum of the four cost center limitations.

There are add-ons to the allowable per diem rate. The add-ons consist of the incentive factor, the real and personal property fee, and the 24 hour nursing factor. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. The 24 hour nursing factor is explained in Exhibit A-18. The add-ons plus the allowable per diem rate equal the total per diem rate.

RETROACTIVE RATE ADJUSTMENTS

Retroactive adjustments, as in a retrospective system, are made for the following conditions:

One, a retroactive rate adjustment and direct cash settlement is made when an audit, by the agency, determines that the historic cost report data used to determine the prospective payment rate is in error. The prospective payment rate period is adjusted for the audit corrections.

Two, when a projected cost report is approved to determine an interim rate, a settlement is made after a historic cost report is filed for the same period.

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And three, when a new provider, through an arms-length transaction, is reimbursed the rate of the prior provider and files a historic cost report for the first 12 months of operation, a settlement is made based on the difference between the interim rate and the rate from the historic cost report.

All settlements are subject to upper payment limits. A provider is considered to be in "projection status" when they are operating on a projected rate or the rate of the old provider and they are subject to the retroactive rate adjustment.

Effective January 3, 1994:

New providers, on or after January 3, 1994, shall not be considered to be in "projection status" when they assume the rate of a previous provider. There will be no retroactive settlement for the first 12 months of operation. The rate effective date for the first historical cost report will be the first day of the month following the cost report period. Rates initially paid after the effective date of the rate based on the first historical cost report will adjusted to the new rate.

For example, a new provider is licensed and certified on March 1, 1994. They assume the rate from the previous provider. They will file the first historic cost report for the period from March 1, 1994 through February 28, 1995.

There will be no settlement for the period from March 1, 1994 through February 28, 1995. The rate effective date from the first historical cost report will be March 1, 1995. Since there is a delay in submitting the cost report and having a rate established, there will be a retroactive rate adjustment from March 1, 1995, until the rate is given to the fiscal agent for payment.

Only providers filing projected cost reports for interim rates will have a retroactive settlement for the historical cost report covering the projected period.

CASE MIX PAYMENT SYSTEM

Kansas is one of four States involved in the national Multistate Nursing Facility Case Mix and Quality Demonstration Project. The case mix payment system was

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partially implemented in Kansas on January 1, 1994. The case mix rate calculation process will follow a process similar to that used under the current system. However, under the case mix system, the Health Care cost center upper payment limit will be adjusted by a facility average case mix index (CMI).

The theory behind a case mix payment system is that the characteristics of the residents in a facility rather than the characteristics of the facility should determine the payment rate. The idea is that certain resident characteristics can be used to predict future costs to care for residents with those same characteristics. For these reasons, it is desirable to use the case mix classification for each facility in adjusting provider rates.

Providers are required to submit to the agency the uniform assessment instrument for each resident in the facility. In Kansas, the Minimum Data Set Plus (MDS+) is the uniform instrument. The MDS+ assessments have been maintained in a computer data base.

Each resident's case mix classification will be determined using the Resource Utilization Group, Version III (RUG III) classification system and the most current MDS+ assessment, for the appropriate time period, in the data base for this resident. From this classification, the numeric value or CMI will be determined. Resident assessments that cannot be classified will assigned the lowest CMI for the State.

Once each resident has been classified, a case mix normalization process will be performed annually. The purpose of this process is to set the mean CMI for the State to a value of one (1). In order to accomplish this calculation, the case mix indices for all residents in the State are totalled and divided by the number of residents. The value determined in this calculation will then be divided into each resident's CMI. This will result in the Table showing the normalized numeric value for each RUGs classification. See Exhibit C-2, Page 11. The average CMI for the State will equal one (1).

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Now that each resident has been assigned a normalized CMI, the facility average CMI can be calculated. The facility average is determined by adding the CMI for each resident and then dividing by the number of residents.

The next step in this case mix system is to set the limit for the Health Care cost center. This process is slightly different than the method used to set limits for the other cost centers. The base limit will be the upper limit for a case mix of one (1), the statewide average.

Each facility will have its unique Health Care cost center limit. In theory, each facility's cost for resident care are directly related to its CMI. Because of this assumption, one would expect providers caring for residents needing heavier care to incur higher costs. Arraying the facilities' costs and setting limits without adjusting the case mix would result in a less appropriate rate calculation.

Determining the case mix allows the agency to array the facilities' costs and set limits with costs that should be more comparable. The first calculation is to determine what each facility's cost would be at a case mix of one. The technique of adjusting costs for case mix is known as neutralizing the costs.

Neutralizing costs is done by dividing each facility's per diem costs by its normalized facility average CMI. The CMIs used to normalize the Health Care cost will be the most current MDS+ assessment in the database as of the last day of the cost report period. This date is used to match as closely as possible the CMI to the time the costs were incurred. When this set of calculations is complete, the neutralized per diem costs are then arrayed and the base upper limit for the Health Care cost center will be calculated using the methodology described for the current system.

The neutralized costs are arrayed. The total resident days are multiplied by the appropriate percentile cap (90th percentile for Health Care). The cumulative days are calculated and the upper limit is found by selecting the per diem cost associated with the number of days at the 90th percentile.

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Each facility's unique upper limit is calculated by multiplying the base limit just established by that facility's normalized CMI. For example, if the normalized case mix index of one (1) results in a base limit of $40, a facility with a CMI of .9 would have a Health Care cost center upper payment limit of $36 ($40 x .9). Likewise, a provider with a CMI of 1.1 would have an upper limit of $44 ($40 x 1.1). The provider would be reimbursed the lower of their inflated Health Care per diem cost or their facility specific, CMI adjusted, upper payment limit.

Case Mix Implementation January 1, 1994:

The case mix payment rate will be phased in for dates of service from January 1 through June 30, 1994. The provider will receive 50% of the rate under the previous system and 50% of the rate under the case mix methodology. There will be a "hold harmless" provision for each provider who experiences a rate reduction based on the case mix adjustment for service days from January 1 through June 30, 1994. The rate from the previous methodology will continue if the case mix adjusted rate is less.

Rates will be adjusted quarterly by the average case mix index for each facility. A detailed listing of the computation for the rate change will be sent to the provider (see Exhibit C-5).

REIMBURSEMENT LIMITATIONS

Period:

The change to the calendar year end reporting in 1991, changed the limitation period. The rates and limitation period, based on the cost reports submitted for the calendar year ending December 31st, will begin the following July 1st. The rates established July 1st for providers not under projection status will stay in effect until the following July 1st, unless otherwise specified by a State Plan amendment.

Upper Payment Limitations:

There are two types of upper payment limits. One is the owner/related party/administrator/co-administrator limit. The other is the cost center limits. Each will be described.

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Owner/Related Party/Administrator/Co-Administrator Limit:

Since salaries and other compensation of owners are not subject to the usual market constraints, specific limitations are placed on the amounts reported. First, amounts paid to non working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have the compensation limited by the percent of their total work time to a standard work week. A work week is defined as 40 hours. The owners and related parties must be professionally qualified to perform services which require licensure or certification.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled "Statement of Owners and Related Parties". This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and a description of the work performed for each owner and/or related party. Any salaries reported in the Plant Operating, Room and Board or Health Care cost centers in excess of the Kansas Civil Service based salary chart are transferred to the administrative cost center where the excess is subject to the Owner/Related Party/Administrator/Co Administrator per diem compensation limit.

The Schedule C is an array of non owner administrator and co-administrator salaries. The schedule includes the most current historic cost reports in the data base from all active nursing facility providers. The salary information is not adjusted for inflation. The per diem data is calculated using an 85% minimum occupancy level for those providers in operation for more than twelve months. The Schedule C for the owner/related party/ administrator/ co-administrator per diem compensation limit is the first schedule run during the annual limitation setting.

The Schedule C is used to set the per diem limitation for all non owner administrator and co-administrator salaries and owner/related party compensation in excess of the civil service based salary limitation schedule. The per diem limit for a 50 bed or larger home is set at the 90th percentile on all salaries

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reported for non owner administrators and co-administrators. A limitation table is then established for facilities with less than 50 beds. This table begins with a reasonable salary per diem for an administrator of a 15 beds or less facility. A linear relationship is then established between the compensation of the administrator of the 15 bed facility and the compensation of the administrator of a 50 bed facility. The linear relationship determines the per diem limit for the facilities between 15 and 50 beds.

The per diem limit applies to the non owner administrators and co-administrators and the compensation paid to owners and related parties who perform an administrative function or consultant type of service. The per diem limit also applies to the salaries in excess of the civil service based salary chart in other cost centers that are transferred to the administrative cost center.

Cost Center Limits:

The Schedule B computer run is an array of all per diem costs for each of the four cost centers-Administration, the Plant Operating portion of Property, Room and Board and Health Care. The schedule includes the most recent historic cost report in the data base from all active nursing facility providers. Projected cost reports are excluded from the data base.

The per diem expenses in each cost center are calculated using an 85% minimum occupancy level for the providers in operation for more than 12 months. All previous desk review and field audit adjustments are considered in the per diem expense calculations. The costs have been adjusted by the owner/related party/ administrator/co-administrator limitations.

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted for historical and estimated inflation, where appropriate. This will bring the costs reported by the providers to a common point in time for comparisons. The historic inflation will be based on the Data Resources, Inc. National Skilled Nursing Facility Market Basket Index (DRI Index) for the cost center limits effective July 1st. The historic inflation factor will adjust costs from the midpoint of each providers cost report period to the latest quarterly DRI Index for the Schedule B processing.

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The estimated inflation factor will be also be based on the DRI Index. Determination of the estimated inflation factor will begin with the quarter the historic inflation ends. It will be continued to the midpoint of the payment limitation period (December 31st).

The final results of the Schedule B run are the percentile compilations. These compilations are the basis for the upper payment limit for each cost center. The upper payment limit percentiles for the cost centers will be weighted based on total resident days. This is a change from past practice. Previously, percentiles were based on the total number of facilities. The current percentile caps are as follows:

Administration	75th
Plant Operating (Portion of Property)	85th
Room and Board	90th
Health Care	90th

The overall Property limit requires additional explanation. The implementation of the real and personal property fee (property fee), effective January 1, 1985, revised the method of determining the property limit. Ownership costs (interest, depreciation, lease or amortization of leasehold improvements) are no longer included in the allowable cost when determining the Medicaid rate. The methodology of the overall property limit needed to be revised after the ownership costs were excluded.

Due to the implementation of the property fee, the calculation methodology of the Total Property cost limit has been revised such that changes in ownership (and resulting increases in ownership costs) after 7/18/84 are not recognized in the percentile limitations. The change in methodology essentially holds the ownership cost portion of the limitations effective 10/1/84 constant. The revised methodology only allows for relative changes in the plant operating costs to influence the total Property cost limit.

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The calculation of the Total Property cost limit is as follows:

Plant Operating 85th Percentile Per Diem Limit from Current Data Base
Minus: Plant Operating 85th Percentile Per Diem Limit from Prior Data Base
Equal: Incremental Change in Total Plant Operating Limit
Add: Total Property Cost Limit from Prior Limitation Period
Equal: Total Property Cost Limit for New Limitation Period

The skilled nursing facilities and intermediate care facilities became nursing facilities on October 1, 1990. The Property cost limit, using the incremental change in Plant Operating costs, was based on the Property cost limit from the 10/1/84 data base for skilled facilities. The incremental changes in the Plant Operating costs and the subsequent change in Property cost limits are now determined from the combined Nursing Facility data base.

The property fee resulted in a calculation of a provider specific plant operating limit. The Total Property limit is reduced, on a provider specific basis, by the amount of the property allowance included in the property fee. In this manner, the non-ownership costs are limited by a cost center limit that excludes the ownership cost portion of the Medicaid rate, or the property allowance. The following is the calculation of the Plant Operating Limit:

Total Property Cost Limit for Limitation Period
Minus: Property Allowance Included in Property Fee
Equal: Plant Operating Cost Center Limit for Limitation Period

It should be noted that the value factor component of the property fee should not be reduced from the Total Property cost limit to determine the Plant Operating Cost Center Limit. The property fee is explained in greater detail in the following section of this exhibit.

Case Mix Adjustment Effective 01/01/94:

The upper payment limit for the Health Care cost center limit will be determined based on the case mix adjustment. This adjustment is explained in detail in that section of this narrative.

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REAL AND PERSONAL PROPERTY FEE

The real and personal property fee (property fee) was implemented, effective January 1, 1985, pursuant to Kansas Administrative Regulation 30-10-25. It was implemented as a response to the Deficit Reduction Act of 1984 regarding re-valuation of assets due to a change in ownership. The property fee satisfies this requirement in that it is the capital reimbursement portion of the Medicaid rate and does not change due solely to a change in ownership. The property fee is facility specific and is in lieu of all depreciation, mortgage interest, lease and amortization of lease expense. The actual ownership costs used to develop the property fee were from the latest cost report for each provider that the agency had processed through July, 1984.

The two components of the property fee are the property allowance and the property value factor. An explanation of each of these follows.

Property Allowance: The four line items of ownership cost (mortgage interest, depreciation, lease and amortization of lease expenses) were added together and divided by resident days to arrive at the ownership cost per diem for each provider. The 85% minimum occupancy rule was imposed on all providers who had been in operation for over 12 months. The ownership per diem cost was reduced proportionately for each provider who had total property costs in excess of the 85th percentile limit on the Property Cost Center Limit. This adjustment to the ownership per diem cost was based on the ratio of ownership costs to total property costs, multiplied by the property costs in excess of the cost center limit. The ownership per diem cost minus this adjustment (if any) resulted in the property allowance.

Property Value Factor: The property allowances for all providers were arrayed by level of care and percentiles established. These percentiles became the basis for establishing the property value factor. The five different groupings developed from each array are as follows:

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Group #	Percentile Ranking	Add-On Percent
1	-0- through 25th Percentile	45%
2	26th through 50th Percentile	15%
3	51st through 75th Percentile	7.5%
4	76th through 85th Percentile	5%
5	86th through 100th Percentile	0%

Once the percentile groups were established, a weighted average property allowance was calculated for each group. This average property allowance was then multiplied by the add-on percentage to arrive at the property value factor for each group. This add-on percentage is inversely related to the percentile ranking. That is, the lower the percentile ranking, the higher the add-on percentage. The property value factor for each percentile group was then assigned to each provider within that group.

There are two value factor arrays. One array is for the Medicare skilled nursing facilities. The other is for nursing facilities which are not certified as Medicare skilled facilities. The value factor is determined based on the classification of the nursing facility and by using the applicable array.

There are two provisions for changing the property fee. One is for a "rebasing" when capital expenditure thresholds are met ($25,000 for homes under 51 beds and $50,000 for homes over 50 beds). The original property allowance remains constant but the additional factor for the rebasing is added. The property fee rebasing is explained in greater detail in Exhibit A-14. The other provision is that an inflation factor may be applied to the property fee on an annual basis.

INCENTIVE FACTOR

The incentive factor is a per diem add-on ranging from zero to fifty cents. It is based on the per diem cost of the Administration cost center and the Plant Operating cost center less the real and personal property taxes expense line. The per diem allowance for these two cost centers less property taxes is determined before the owner/related party/administrator co-administrator limitation is applied.

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The incentive factor is designed to encourage economy and efficiency in the administrative and plant operating cost areas. Property taxes were excluded since the provider has little control of the cost. There is an inverse relationship between the incentive factor and the per diem cost used to determine it. The higher the per diem cost, the lower the incentive factor.

The Schedule E is an array of the per diem costs that are used to determine the incentive factor. The schedule includes the costs from the most recent historical cost report for all active providers. No projected cost reports are included. The per diem costs are based on the 85% occupancy rule. The costs are not adjusted for inflation.

The Schedule E summarizes all expense lines from the Administration cost center and the Plant Operating cost center, less property taxes. The ownership costs are excluded from the array so that both older facilities (with relatively lower ownership costs) and newer facilities (with relatively higher ownership costs) can benefit from the incentive factor through efficient operations. The Room and Board and Health Care cost centers are excluded from the incentive factor calculation so that providers are not rewarded for cost efficient operations with regard to costs that may jeopardize the direct care of the residents.

The total per diem costs for administration and plant operating, less property taxes, are arrayed and percentiles established. These percentiles then become the basis for establishing the per diem cost ranges used to determine each providers efficiency factor, consistent with agency policy. The ranges are defined as follows:

Providers Percentile Ranking	Incentive Factor Per Diem
-0- to 30th Percentile	$.50
31st to 55th Percentile	.40
56th to 75th Percentile	.30
76th to 100th Percentile	-0-

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INFLATION FACTORS

Historic and estimated inflation will be applied to the allowable reported costs from the calendar year end cost reports for rates effective July 1st. The historic inflation will be based on the Data Resources, Inc. National Skilled Nursing Facility Market Basket Index (DRI Index). The historic inflation will be applied from the midpoint of the cost report period to the latest quarterly DRI Index available.

The estimated inflation will begin with the quarter the historic inflation ends. It will be continued to the midpoint of the payment limitation period (December 31st). The estimated inflation factor will be based on the DRI Index. This annual percentage estimate is used consistently throughout the limitation period.

The DRI Indexes published for the latest available quarter will be used to determine the historic and estimated inflation tables for the Schedules A-1 and A processed during the payment limitation period. This will require the use of forecasted factors in the historic table. The inflation tables will not be revised until the next payment limitation period.

For historic cost report periods ending other than the last month in a quarter, the inflation factor to be used in the calculation will be the factor for the quarter in which the cost reporting period ends. For example, a cost report period ended August 31st, will receive inflation based on the calculation using the September, third quarter, DRI Index forecast. This approach is being used instead of trying to convert a quarterly index into monthly factors.

Schedule A-1 historic and estimated inflation(Exhibits C-2, pages 2 and 5, respectively) are applied in determining rates with an effective date of July 1, 1993. Schedule A historic and estimated inflation (Exhibits C-2, pages 1 and 4, respectively) are applied in determining rates for non calendar year historic cost reports with rate effective date other than July 1, 1993.

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The inflation factors are applied to all costs except the following:

Allowable Costs:	Exempt From Historical	Exempt From Estimated
1. Salaries:		
Administrator	Yes	Yes
Co-Administrator	Yes	Yes
All Other Non Owner Employees	Yes	No
2. Payroll Taxes	Yes	No
3. Owner's Compensation	Yes	Yes
4. Interest Expense other than Real Estate Mortgage	Yes	Yes
5. Real Estate Taxes	Yes	Yes
6. Personal Property Taxes	Yes	Yes

RATE EFFECTIVE DATE

Rate effective dates are determined in accordance with Exhibit A-7. The rate may be revised for an add-on reimbursement factor (i.e. rebased property fee or 24 hour nursing), desk review adjustment or field audit adjustment.

COST CENTER LIMITATIONS
Effective January 1, 1994 - June 30, 1994

NURSING FACILITY

Administration	$7.65
Property	$9.74
Room & Board	$16.74
Health Care	$38.64*

* Base limit for a facility average case mix index of 1.00